Illinois Hospital Association

November 25, 2013

The Honorable Cristal Thomas
Deputy Governor
Thompson Center, Floor 16-100
100 West Randolph
Chicago, IL 60601
Re: Medicaid 1115 Waiver Draft Concept Paper Comments

Dear Deputy Governor Thomas:

On behalf of its more than 200 member hospitals and 23 health systems, the Illinois Hospital Association (IHA) appreciates this opportunity to provide written comments on the draft Medicaid 1115 waiver concept paper released on November 8, 2013. A comprehensive 1115 waiver presents a substantial opportunity for Illinois to secure much needed federal investments in the state's health care delivery system, with a focus on how all providers can work together to ensure the health and well-being of all Illinoisans. IHA commends the state for producing a thoughtful concept paper. While any final position on the eventual waiver application will depend upon its specific components, we are encouraged by the direction and goals articulated in the concept paper.

Having served their communities in many cases for over 100 years, Illinois' hospitals and health systems know that it takes much more than "traditional" medical care to achieve healthy communities. The predominant model of health care delivery for IHA members has evolved to support enhanced quality of life for communities by identifying and addressing health and social needs. Hospitals and health systems provide a broad range of services – not just "traditional" emergency, trauma, inpatient/acute and surgical care – and not just within the walls of their buildings – but well beyond those walls, all across their communities. Hospitals and health systems currently provide the following services: extensive preventive and primary care services, post-acute services, (including skilled nursing, rehabilitation, long-term care, home health, palliative and hospice care), and mental health and substance abuse programs. Illinois' hospitals and health systems also provide free and subsidized health services, wellness programs, support groups, medical research, and neighborhood revitalization projects.

In addition, our hospitals and health systems are training the next generation of physicians and other critically needed health care professionals to meet the workforce needs of the state's health care delivery system, often within training programs where the costs exceed the financial support for training. Hospitals and health systems are truly the cornerstones of their communities and the state's health care delivery system and the key mechanism to integrate various providers to form an integrated delivery system (IDS) and provide care across the continuum.

Delivery System Transformation

It was encouraging that the concept paper focused on the need for the development of integrated delivery systems because Illinois hospitals are committed to this type of transformation. Providing additional incentive payments or enhanced primary care rates for those medical homes that are clinically integrated with an IDS would reward those medical homes that have already invested in delivery system transformation and would incentivize those that are in the process.

One option to consider would be linking additional payments to those medical homes within an integrated delivery system that have been certified by a nationally recognized certification process. A primary care medical home that has demonstrated its commitment by becoming certified would be a worthwhile investment. Such an incentive should be available, in addition to payments from managed care organizations or fee-for-service payments from the state. The waiver presents the state with an opportunity to incentivize the care coordination activities of those medical homes that are part of an IDS.

The focus on needed integration of behavioral and physical health is a high priority for IHA and we are pleased to see it incorporated prominently into the concept paper. Too often, the community supports needed to support individuals with serious behavioral health needs are unavailable and the hospital emergency department stands as the safety net when exacerbations occur. For individuals with both serious behavioral health needs and chronic medical conditions, the value proposition of integrated delivery is even greater. Funding for integration and the development of behavioral health crisis teams is needed and will lead to better care coordination and lower costs. There are a number of pilot programs underway in Illinois. However, additional funding is needed to support the success of these programs. The waiver should present a process for all providers with effective integration models to apply for such funding.

The concept paper lists a number of potential hospital transformation pools that are linked to quality care improvement, development of integrated delivery systems, and support for the health information technology/health information exchange (HIT/HIE) infrastructure. **We fully support such incentive pools that would involve performance metrics. However, given the uncertainty of the distribution of the incentives and the likely increased financial responsibility to achieve acceptable performance levels, the payments must not be financed by the current or a new tax or assessment on hospitals, but appropriately from new waiver funding.** Additionally, a hospital transition pool that would provide funding or debt relief for hospitals reducing their inpatient capacity would be an effective method to incentivize more hospitals to change their delivery system and increase their outpatient capacity to be more in line with future health care demands.

We appreciate the State's recognition of the challenges presented in providing services to uninsured and low-income communities. We particularly support the efforts aimed at preserving and enhancing the critical financial support that is needed to assure access to care through an access assurance pool. An access assurance pool is a possible mechanism for allowing the state to at least preserve the current level of federal funding financed by the current hospital assessment. As such the distribution should be based on unreimbursed costs, not added performance metrics.

The recognition of the importance of accountable care entities (ACEs) and care coordination entities (CCEs) was encouraging. However, it will be incumbent upon the state to ensure that these entities have sufficient covered lives assigned that are aligned to each entity’s goals. The state has an important role in providing stability and predictability to the CCEs and ACEs as they begin implementation. Allowing only limited assignment of lives to CCEs threatens the credibility of this important innovation. We agree that technical support and funding to support their startup and implementation would be an investment that would provide substantial returns in terms of costs savings and improved outcomes. In particular, we have heard from some providers considering the ACE

opportunity, that the health information exchange (HIE) requirements may involve substantial costs, especially for those ACEs that involve multiple provider organizations. We believe that such a requirement needs additional flexibility, but the waiver can serve as a mechanism to subsidize these HIE costs borne by providers so as not to be an impediment.

Population Health

Focusing on evidence-based prevention and wellness strategies holds promise and we look forward to more details on what payment reforms for wellness programs might be considered. Funding to support educational initiatives that strengthen the health literacy of individuals and communities as well as access to patient navigators can optimize the use of health and community resource and lower long-term costs. Also, the waiver should include providing value-added services to incentivize healthy behaviors, e.g., obesity reduction, smoking cessation, and participation in chronic condition management programs and other health and wellness initiatives.

The concept paper identifies an opportunity for the state and local health departments to collaborate with local hospitals to share data obtained through the community needs assessment. Such voluntary collaboration has potential to align efforts to address the highest priority needs within communities. The health of our communities is an issue that hospitals are uniquely suited to address as a convener of a wide range of providers and social service agencies. We recognize that the waiver can play an important role in improving population health that will benefit communities throughout the state. For example, providing incentives for hospitals to achieve Baby-Friendly designated status would be one way to improve children's health through breast-feeding. Steps to achieve designation include recommending breast-feeding over formula to pregnant patients and educating women on the health benefits.

Workforce

IHA shares the goal of increasing the number of primary care providers in Illinois, but primary care must be viewed in a comprehensive manner consistent with fostering integrated delivery systems. Therefore, using the Affordable Care Act's primary care residency program definition, the following graduate medical residency training programs should be eligible for the incentive program: family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry and geriatrics. In addition, emergency medicine, psychiatry, and general surgery should be considered part of a comprehensive primary care definition, are in short supply, and are an essential element in developing integrated delivery systems. Also, the incentive program should be structured so that the academic medical center or health care provider sponsoring the accredited residency program is the organization that receives the incentive funding. This will allow the program to select the most suitable site for training that meets the criteria of the incentive program, while also recognizing the training slots that the accredited training programs support at other locations. While there are various measures of underserved areas or health professional shortage areas, latitude must be given for training sites that may not be physically located in an underserved area, but provide care to underserved populations today. Such flexibility will help to ensure that qualified training programs have flexibility in choosing the medical home training sites that are best suited to train resident physicians.

The issue of physician supply and specialty distribution is extremely complex as demonstrated by a 2010 Illinois resident physician survey that identified that approximately

one-half of graduating Illinois residents and fellows leave the state after completing their training. Therefore, the state should also take a comprehensive approach in evaluating future workforce needs that are based on accurate data and sound projections. Such research is needed to examine the underlying factors affecting physician practice setting decisions.

The concept paper correctly acknowledges that Illinois is one of only a handful of states whose Medicaid reimbursement does not recognize the cost borne by hospital providers to train medical professionals. As a result, Graduate Medical Education (GME) programs in Illinois are faced with substantial unreimbursed costs related to the services purchased by the Illinois Medicaid program. As the Illinois Medicaid program becomes a more dominant purchaser of healthcare services, it becomes even more important to recognize the state's role and responsibility to appropriately share in the cost of assuring a sufficient medical work force into the further. While Illinois needs to increase its supply of physicians, the GME waiver pilot should be only one element in a strategy that goes beyond simply incentives for GME programs. The state needs to take a comprehensive approach to influencing physician specialty and location choice.

The loan repayment proposal that includes a broad range of physician specialties and professions is sorely needed, especially for underserved and rural areas. We recommend using the same specialties listed above eligible for the GME incentive program for any debt forgiveness program. Also, flexibility should be given when evaluating underserved areas. Although there are recognized criteria for defining an underserved area, a particular specialty may be in short supply in a location that does not qualify as underserved, due to an adequate supply of physicians practicing in other specialties. Therefore, local providers should be given an opportunity to demonstrate need, even if they are not located in an officially designated underserved area.

Rate enhancements for practicing in underserved areas or serving underserved populations as part of an integrated delivery system should also be explored as a more immediate way to increase capacity. We also support efforts beyond GME initiatives that would allow all clinical staff to practice to the full extent of their training. Without removing barriers for other clinical staff to practice in a team based environment, access to care impediments cannot be fully resolved.

Other Issues

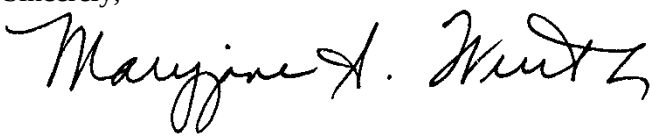
While the concept paper contains a number of proposals for enhancing care coordination, the paper does not make specific recognition for the needs of the 68 rural counties in Illinois. We recommend consideration of a Rural Health Innovations Program (RHIP). The RHIP would be specifically designed to accomplish the following: support the ability of rural providers to establish Patient-Centered Medical Homes (PCMH) with integrated behavioral health services, develop regional care coordination entities, and leverage technology and telemedicine for quality improvement and population health services. Many counties currently lack the necessary community support services to provide comprehensive care to Medicaid beneficiaries. A regional infrastructure for rural health providers to develop comprehensive community-based programs to ensure access to quality health care services for Medicaid patients should be specifically addressed.

The executive summary states that the waiver will include all spending in the Illinois Medicaid Program. It would be helpful if this statement were clarified as to the intent of

how the waiver will affect Medicaid spending. The current statement could be interpreted that all existing Medicaid payment systems will be changed due to the waiver.

Thank you for the opportunity to comment on the concept paper and we are optimistic that this effort will provide much needed investment in the Medicaid program to accelerate its progress on the path to transformation. If you or your staff have any questions or comments, please contact Patrick Gallagher at 630-276-5496 or pgallagher@ihastaff.org.

Sincerely,



Maryjane A. Wurth
President & CEO